This article was written in response to ART vs REHAB, a critical catalyst for those working creatively within addiction, the criminal justice system, homelessness and mental health. For more information, please visit artvsrehab.com.

Conflicts in Care: How do artists navigate notions of autonomy, collaboration and patronage in care settings?
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I am floating within a post-graduate space of consolidation of my personal art practice and my need to earn a living. I have a professional background in health and social care and my practice leans towards social engagement, collaboration and participation. I have a personal desire to make art and am also drawn art practice within a care setting. I know that art making is a therapeutic activity but recognise that I am not a trained art therapist.

In addition, my personal position has changed recently through the uncomfortable recognition of my own physical limitations and a new label of 'disability' resulting from a diagnosis of a common medical condition that is, for the most part, invisible to others. Because of this alteration, I have taken on a new form of questioning which has lead me to consider, with some unease, issues around the intentions of my own art practice, of my commissioners and how these motivations may impact on clients and participants.

There is an additional impact when financial reward is brought into the exchange equations previously discussed in projects such as Modalities of Exchange, (Alison Rooke, 2012) and wider discussions of the Department of Health (2007). How does the need for financial remuneration affect the decision of artists such as myself to work in care or health settings when arts funding generally is becoming increasingly scarce?

The therapeutic value of arts activities and commissioned projects is well accepted nationally and locally. Marcus Coates' The Trip, where the role of artist as vicarious agent for imagination and experience is explored within the context of a hospice, is just one illustration of how effectively art and creativity can act as a positive catalyst to new possibilities at the end of life (Andrew Gallini, 2012). However, I have past experience of projects that, despite being carried out by well-briefed and well-intentioned artists, produce work that is directed by the artist with only token collaboration (despite otherwise enthusiastic creative and useful participation).

I am personally struggling with the reconciliation of a truthful balance of the leaky boundary between my artistic autonomy and the agency of those with whom I work. This is particularly pertinent as I originally summoned the courage to develop an art practice after being privileged to witness work produced by the people with learning disabilities with whom I worked in a day-care setting.

Some projects developed through an artist's autonomous personal vision and able to attract external funding from a variety of sources maybe seen as boundary-breaking and challenging of stereotypes by one audience but tokenistic and patronising by another. Meanwhile, the participants enjoy, thrive and develop new skills that they then exhibit to a wider audience (or alternatively are manipulated and exploited depending on point of view). Claire Bishop addresses questions of a 'directly ameliorative approach to social participation and states that 'good collaboration doesn't necessarily produce good art.'(Bishop, 2009,p 3).

The added confusion of commissioning agencies and funders makes negotiating this liminality of practice even more uncomfortable:

- Often there is a desire for a known artistic outcome, reduced understanding of process and a focus on quantity (of workshops and numbers of participants for example).

- Projects may be short-term, where the development of ethical relationships is severely limited by time.

- Artists may feel their autonomy is compromised and a full interrogation of the process by all participants is not possible.

- If the artist themselves applies for (and receives) funding, this also changes the power dynamics of the collaborative or participatory relationship and the working process of the artist.

- Artists (maybe myself) may use projects to extend their experience and professional cv's, to provide income and to validate their professional practice.

How often does this result in clumsy and possibly exploitative projects, and what changes are necessary to make the process and outcomes more effective for all concerned; service-users, carers, funding bodies and artists?

Discussions with fellow artists and care professionals highlight concern, particularly for vulnerable groups such as those with learning disabilities, dementia or who are non-verbal, where personal advocacy may be an issue, and also where pain, physical discomfort and other basic care needs alter the dynamics of the relationship.

The essential recommendations made by Modalities of Exchange (Alison Rooke, 2012) came from full analysis of five embedded multi-year residencies with older people and a search for good practice. I feel that possibly the most valuable and transferable recommendation is that of exchange of empathy and a process of changing of perceptions from a sympathy or 'helping' mindset to the development of empathetic relationships. (Alison Rooke, 2012)

Moss and Neil (2009) call for artists working in healthcare to undergo formal training and recognised accreditation to overcome the likelihood of employment of 'maverick' artists and so that issues such as personal care and health needs, ethics and self-awareness and motivation may be considered in association with health and care professionals. Would such training help artists to develop empathetic relationships or would artists feel that this path restricted autonomy and restricted practice?

Maybe consistently addressing open recognition and discussion of the (trial and error?) process of development of experience in care and health settings, as discussed by Hannah Hull in ART vs REHAB focus group (Hannah Hull, 2012) would be more beneficial?

Whilst art therapists 'integrate the experience of a given art form with processes of psychotherapy… and psychiatry', (The Dept. of Health, 2007) with therapeutic process and outcome as a priority, artists prioritise artistic outcomes and processes, with therapeutic benefits as secondary considerations.

Maybe what is really necessary is what Chris Jones (2012) describes as complete honesty on the part of the artist concerning motivation regarding the work and the working relationship(s). From this point of openness, discussions regarding process and possible outcomes can begin and along with them the process of true exchange starts. In some cases this may produce 'situations of conflict and unease since the artist does not pretend to be a facilitator of others, but is explicitly self-reflexive about his/her role as motivator and manipulator' (Claire Bishop, 2009 p 2). Bishop states that 'these works don't just concern themselves with process but also with the (conceptual) product of these gestures, with their meaning beyond the satisfaction of their immediate participants'.

If honesty is not present, I suggest that the exchange is unethical with a false representation of collaboration and participation and is possibly more concerned with what Claire Bishop refers to as 'careerist individualism of the artist' (Bishop, 2012 p2). Karen Parker (2012) also

reflects on the courage necessary for the artist as facilitator to acknowledge that the client group may have a ‘better’ idea than the artist’s initial vision and the ability to work with the altered proposal.

In the history of art, patronage has provided financial support to artists whilst in some cases endorsing political aims, personal prestige and status. The artist has provided skills and resources that the patron does not have and the artist, in a fair exchange, receives the patronage.

In the case of art within health and care settings, there is a therapeutic benefit from the artist’s input and the employment of the artist is funded as part of their care. Chris Jones (2012) states this to be a fair exchange when the artist really does serve the needs of the client group but that it ‘gets messy’ when the client does not directly fund the artist.

As socially- engaged artistic practice becomes commonplace, arts funding is squeezed further and personal commissioning of health and care budgets becomes customary, the open addressing of these issues may lead to opportunities for all, including especially vulnerable groups to become financial patrons of their artistic process. The drive towards “personalised budgets” should lead to the clients themselves having increasing power to demonstrate that they value the work of artists and when honesty in collaboration is present, over time, trust can develop and the artist receives far more than financial reward for their artistic expertise in a mutually remunerative relationship. (Chris Jones, 2012).

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